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TOPICS:

I. SERVICE/PRIOR AUTHORIZATIONS (PA)

1. How will Prior Authorizations (PAs) be transferred to another Health Plan? How will this work at the December 1 program start date?

The Plans will be notified of existing Prior Authorizations in the electronic enrollment file sent to them for each member that selected that plan. Health Plans are contractually obligated to honor prior authorizations in place for up to 90 calendar days as members move from fee-for-service (FFS) Medicaid to MCM Health Plans.

2. What about prior authorizations (PAs) when a member moves from one Health Plan to another, does the receiving Health Plan have to honor another Health Plan's authorizations?

The receiving Health Plan does not have to honor any authorizations issued by another Health Plan. Contractually, the Health Plans are required to provide information to members regarding prior authorizations (PAs) in their Member Handbook in the event a member chooses to transfer to another Health Plan. Member Handbooks will be mailed to each member; they are also available at each of the Health Plan websites.

3. Where can we find eligibility coverage and authorizations for each Health Plan?

Providers can check eligibility for Medicaid and client Health Plan enrollment by going to the Health Enterprise MMIS operated by Xerox. The Health Enterprise will show both Medicaid eligibility and the Health Plan the client belongs to (if applicable). In addition, each of the Health Plans will be able to perform this function. Providers must contact the client's Health Plan to seek an authorization or to determine if one has already been approved. (DHHS will be issuing the *Quick Reference Guide* at the end of October that will contain this contact information for each Health Plan and Xerox.)

4. Will all Health Plan coverage and authorizations be on the MMIS?

Health Plan coverage - meaning the Health Plan selected by the NH Medicaid member -will be available through the Health Enterprise MMIS webportal and AVR system. Each Health Plan also has the ability to check Health Plan coverage through the health Enterprise MMIS webportal. However, prior authorizations (PAs) issued by the Health Plans will not be visible on the MMIS – only those issued by fee-for-service (FFS) Medicaid. Providers will need to use the Health Plan's provider portal or call Provider Relations. (DHHS will be issuing the *Quick Reference Guide* at the end of October that will contain this contact information for each Health Plan and Xerox.)

5. Where will providers submit requests for prior authorizations (PAs) for each Health Plan?

Providers need to refer to their Provider Manuals for each Health Plan on how to submit service authorization requests. (DHHS will be issuing the *Quick Reference Guide* at the end of October that will contain this contact information for each Health Plan and Xerox.)

6. How will service authorizations for CFI (Choices for Independence) waiver clients be handled under Managed Care? Do options change?

CFI waiver services are not included in Step 1 of MCM; therefore, there will be no changes in how service authorizations are currently handled or in their choice of options.

7. What are the prior authorization (PA) procedures for medications?

Each Health Plan will have a procedure. For clients, it is best to call Member Services or consult the Member Handbook for that particular Health Plan. Providers will need to refer to their Provider Manual and/or contact the Health Plan(s). (DHHS will be issuing the *Quick Reference Guide* at the end of October that will contain that contact information.)

II. ENROLLMENT/CALL CENTER

1. How often is the eligibility system updated? It is updated overnight each business day.

2. How often will the Health Plans update the Health Enterprise MMIS (Xerox) with new information? It is sent overnight each business day.

3. What are the Call Center hours?
Enrollment Call Center Hours: 8:30 am until 7:00 pm, Monday through Friday.
Medicaid Client Services Call Center: 8:00 am until 4:30 pm, Monday through Friday.

4. How will non-English speaking clients be assisted via the enrollment process and on-going with Health Plans? Are interpreters available at the Enrollment Call Center?
Enrollment Call Center: The Enrollment Call Center has Spanish-speaking staff; for other languages, staff use the Language Line.
Medicaid Client Services: Staff use the Language Line.
Health Plans: The MCO is obligated to communicate in ways that can be understood by persons who are not literate in English or their native language. Accommodations may include the use of audio-visual presentations or other formats that can effectively convey information and its importance to the member's health and health care. The Health Plans will not rely upon family members to provide interpreter services.

5. Will clients need to select specialists at some point, or do they just need to change specialists if they are not enrolled with same Health Plan as the PCP?
First, the client should ask their Health Plan if that specialist is in the process of enrolling with them. Part of the responsibility of the Health Plans will be to work with the member to develop a plan of care to assure specialty care needs are met. Additionally, providers are being added to networks every day, as their credentialing is completed. As such, the networks are very fluid at this time. If a provider doesn't appear in the network today, it does not mean they won't be in the network in the near term. The provider's office can indicate whether they have contracted with a Health Plan (and is awaiting listing in the network directory) or not if a member needs to know right away.

6. If a client calls the Enrollment Call Center number and selects a Health Plan and PCP, will the client be told if that PCP is not part of the Health Plan they selected?
When addressing the client's enrollment options, the Enrollment Call Center will tell the client if that PCP is listed in each Health Plan prior to their selection of a Health Plan. A client can still complete their enrollment without selecting a PCP and manage their PCP selection directly with the health plan.

7. The "HOW TO COMPLETE INSTRUCTIONS" (for the Selection Form) is listed on the last page of the client letter. The instructions appear very specific in order to guarantee proper processing. Wouldn't it be beneficial to have these listed on the front page so that clients do not make errors, then learn what not to do after the fact? Listing those instructions on the last page guarantees issues.
DHHS appreciates the suggestion but is not able to change the form at this time. DHHS guarantees that if a form is not filled out correctly (cannot be read by the scanner) every attempt will be made to process it manually. Alternatively, if the form cannot be processed manually, Medicaid Client Services will contact the member to process their enrollment.

8. For redeterminations due 9/10 & 10/10, will clients receive this additional enrollment package?

Redeterminations will be mailed regardless of a client's MCM participation status. If a client does not complete their redetermination, they could lose their Medicaid eligibility. Clients must complete their redeterminations to maintain their medical assistance. Medicaid Care Management Enrollment Packets will be mailed separately from any other DHHS correspondence, including redeterminations. Redeterminations should not be returned in the MCM enrollment self-addreses stamped envelope.

9. For new applications, are we still completing an 800?

Yes, initial applications for NH Medicaid will still be processed by DHHS.

10. Will the Enrollment Call Center ask a client if a case manager is involved and, if so, will they direct them back to the case manager?

Currently, the Enrollment Call Center staff only asks about a case manager if the client is very confused and states they need more help.

11. Will the local District Office (DO) be taking walk-in's for face-to-face assistance with MCM Health Plan selections?

The District Office staff will not complete Health Plan selections but they can answer questions about Care Management. If a client walks into a District Office (DO), the front desk staff will answer basic questions about Care Management. A supervisor will assist with more difficult questions.

12. Why are providers and not District Offices (DOs) helping clients with this decision?

For Step 1 enrollments, Medicaid Client Services and the Enrollment Center are assisting clients to enroll in a Health Plan. However, many providers have expressed interest in supporting their patients in this process, which DHHS greatly appreciates. That said, it is not a requirement nor expectation that providers will engage in enrollment activities for patients. For those providers that choose to do so, the provider training and community forums offer the information they will find most useful for that purpose.

13. Do you have a blank Enrollment Packet available if a client has lost theirs?

If a client loses their enrollment packet, they should call either the Enrollment Call Center or Medicaid Client Services and request another packet be mailed to them. The enrollment letter and form are case specific so no blank packets are available. Clients with a NH EASY account can access their letter there and print out another copy. Alternatively, they can just enroll by phone with the Enrollment Call Center without the packet.

III. PROVIDER DIRECTORIES / PCP CHOICE

1. If a long-term care (LTC) patient has to pick a PCP but the PCP that comes to the facility is not an option what do you do?

While each plan is required to ensure that all members have regular source of primary care, this does not mean that every member must choose a primary care provider from the Health Plan's network. Nor does it mean that the member must select a PCP at the time of enrollment. The resident or their authorized representative can explain that primary care is already provided by the facility and it is likely that the Health Plan will not require the resident to make a selection.

2. How can continuity of care be talked about when not all providers are signed up and a client is forced to choose providers despite long-term care?

Continuity of Care means no gaps in coverage; it does not mean that the providers remain the same, though that is optimal. It could mean that a new plan of care is in place as of December 1 to ensure no gaps in service occur.

IV. EXEMPT MEDICAID RECIPIENTS/SERVICES

1. QWMB/SLMB exemptions – are they exempt even if they are also on APTD?

No. Someone who has both Medicare and Medicaid (APTD) is a dually eligible and is a voluntary participant in MCM. Those with QMB *only* (no Medicaid) are exempt. These QMB only individuals receive assistance with their co-insurance and deductibles for Medicare; they do not receive Medicaid benefits.

V. BENEFITS/COVERAGE

1. Will there be a list published for Durable Medical Equipment (DME) providers with the CPT codes that are covered under MCM versus those covered under Medicaid FFS?

The Health Plans must provide the same level of service as FFS. There are no DME items that are outside of MCM. Therefore there is no need for a list of items covered FFS vs covered MCM. Only people who remain FFS through Step 1 will have their DME covered by FFS.

2. Will any DME items be carved out with payment on the FFS side?

See above.

3. Do any of the Health Plans cover ABA?

ABA is not currently a Medicaid State Plan service. While the Health Plans are free to offer services over and above what is presently covered on Medicaid, specifics of those coverages should be discussed with the individual Health Plans.

4. What will happen to members who have been receiving services at Boston Children's Hospital?

At this time, the network is very fluid; providers are being added every day. If Children's Hospital is not part of a Health Plan's network, and there is a service that ONLY Children's can provide, the Health Plan will make an out-of-network arrangement with Children's Hospital to provide that service. Every attempt will be made to serve that patient in network, if possible. Each plan is presently negotiating with Children's Hospital and we remain hopeful that the parties will agree to terms that are mutually satisfactory leading to Children's inclusion in all networks.

5. What about those who have been receiving services from specialists in different places?

Part of the responsibility of the Health Plans will be to work with the member to develop a plan of care to assure specialty care needs are met.

6. Is a Health Risk Assessment required to be completed?

No. All of the MCOs have a Health Risk Assessment (HRA) questionnaire to use with members, but whether a member completes the HRA or not will not impact the delivery of their health care services. However, Medicaid recipients are encouraged to complete the HRA to inform the Health Plan if they have special needs or could benefit from additional services the Health Plan may offer.

7. Will MEAD clients have all have the options for extensions if they lose their employment? Or would they have to immediately enroll in a Health Plan?

Eligibility for MEAD remains the same and is not impacted by MCM. MEAD clients are mandatory in the MCM program, meaning they will either choose a Health Plan themselves or be autoassigned to one.